

Patient Label



809 W. Church Street, Champaign, IL 61820
Phone: (217) 373-1700 Fax: (217) 373-1767

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: Birth Date:
Maiden/Prior Names: Current Phone #:
Current Address:

I am requesting disclosure of my protected health information for the following purpose:

- Continuing Care, Academic, Disability Determination, Legal Investigation, Child Custody, Other

I authorize the release of the following:

- Comprehensive Assessment, History and Physical, Psychological Evaluation, Alcohol and Drug Abuse, Education Reports, Progress Notes, HIV Test Results and AIDS Treatment Records, Lab/Diagnostic Reports, Discharge Instructions, Continuing Care Plan, Discharge Summary, Other

To be released by:

The Pavilion, 809 W. Church St., Champaign, IL 61820
Name/Agency, Address, City, State, Zip, Relationship, Phone

To be released to:

The Pavilion, 809 W. Church St., Champaign, IL 61820
Name/Agency, Address, City, State, Zip, Relationship, Phone

This authorization will expire on ___/___/20___. (If not indicated, authorization will expire one year from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. You right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

Patient's signature (required for ages 12 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

Witness signature (required) Date Signed

This authorization is intended to allow The Pavilion to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. The Pavilion is not liable for such re-disclosures.